Supreme Court, U.S.
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(2)

No. 91-1197

In the Supreme Court of the United States

OCTOBER TERM, 1991

WESTCHESTER MANAGEMENT CORP.
dba SALEM PARK NURSING HOME, PETITIONER

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Whether the district court lacked jurisdiction over petitioner's claim for reimbursement of rental expenses under the Medicare Act because the claim did not meet the $10,000 amount-in-controversy requirement of 42 U.S.C. 1395*oo*.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 2a-9a) is reported at 948 F.2d 279. The opinion of the district court (Pet. App. 10a-14a) is unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 1a) was entered on November 5, 1991. The petition for a writ of certiorari was filed on January 22, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Under Part A of the Medicare program, 42 U.S.C. 1395 *et seq.*, eligible beneficiaries obtain hospital and post-hospital services from "provider[s] of services," including hospitals, skilled nursing facilities, and home health agencies. See 42 U.S.C. 1395x(u). The government reimburses the providers of services for the services that they provide to beneficiaries.

a. Congress has established a complex system for handling the vast numbers of claims for payment submitted to the Medicare program each year. Congress has authorized the Secretary of Health and Human Services to contract with "fiscal intermediar[ies]," primarily insurance companies, to act as the Secretary's agents in handling claims for payment. 42 U.S.C. 1395h(a). This approach allows the Secretary to draw on the fiscal intermediaries' experience and skill in dealing with claims for payment for medical care.

At the end of each year, a provider of services submits to its fiscal intermediary a cost report for Medicare services rendered during the year. The fiscal intermediary reviews the cost report and applies the Medicare Act, the regulations promulgated under the Act by the Secretary, and other directives of the Secretary contained in the Medicare Provider Reimbursement Manual.[1] After reviewing the cost report, the intermediary issues a Notice of Program Reimbursement to the provider. See 42 C.F.R. 405.1803. This notice specifies the amount of reimbursement to which the intermediary believes the provider is

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[1] In issuing these regulations and directives, the Secretary acts through the Health Care Financing Administration (HCFA).

entitled. The notice also informs the provider of its appeal rights.

If the provider is aggrieved by the notice—and the amount in controversy is $10,000 or more—the provider may appeal to the Provider Reimbursement Review Board (Board). 42 U.S.C. 1395*oo*(a). A group of providers, each of whom would be entitled to appeal to the Board but for the amount-in-controversy requirement, may bring a joint appeal on a common question of fact or law if the aggregate amount in controversy is at least $50,000. 42 U.S.C. 1395*oo*(b). A provider or group of providers that has a right to appeal to the Board may (with exceptions not relevant here) obtain judicial review of the Board's decision by filing a civil action within 60 days after it is rendered. 42 U.S.C. 1395*oo*(f) and (g). The statute also provides for judicial review of an action of a fiscal intermediary, including review of legal issues that the Board may not have authority to decide, by permitting a provider or group of providers that meets the jurisdictional prerequisites for Board review to seek a determination from the Board that a pertinent question of law is beyond its authority to decide. See 42 U.S.C. 1395*oo*(f)(1). When the Board makes such a determination, the provider or group of providers may obtain immediate judicial review of the legal question at issue. *Ibid.*

A single provider aggrieved in an amount between $1,000 and $10,000 is entitled to a hearing before the fiscal intermediary rather than the Board. The hearing is conducted by an officer who is knowledgeable in the field of health care reimbursement and who has had no direct responsibility for the program reimbursement determination with respect to which a request for a hearing was filed. 42 C.F.R. 405.1809,

405.1817. The hearing officer's decision is final and binding unless it is reopened upon motion of the hearing officer or provider, 42 C.F.R. 405.1833, 405.1885, except that upon motion of the provider or at the discretion of HCFA, a HCFA review officer may review the decision. HCFA Pub. 15-1, § 2917 (2/85). There is no appeal from the decision of the HCFA review officer. *Ibid.*

b. The amount of reimbursement to which a provider is entitled is determined in accordance with applicable statutes and regulations issued by the Secretary. This case concerns the Secretary's regulation governing the allowability of costs for services, facilities, and supplies furnished to a provider by an entity related to it by common ownership or control. The regulation applicable to this case provided:

> Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.
>
> * * * * *
>
> Where the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself.

42 C.F.R. 405.427 (1984).[2] These provisions prevent corporate Medicare providers from inflating costs by means of intra-corporate transactions that do not add to the actual costs of services.

This case concerns rent paid by a provider under a long-term lease that was signed before a change in the ownership of the provider. The Medicare Provider Reimbursement Manual deals with this situation by providing:

> If a provider and a supplier are related by common ownership or control at the time of executing a supply contract, the provider's allowable costs will be governed by the related organization principle throughout the full term of the supply contract, even if the common ownership or control terminates before the end of the contract.

HCFA Pub. 15-1, § 1011.2 (12/82).

2. Suburban Nursing and Mobile Homes, Inc. (Suburban) owned the facility known as the Salem Park Nursing Home (Salem Park).[3] On January 1, 1977, petitioner leased the facility from Suburban for a ten-year term. At the time of the lease transaction, petitioner and Suburban were related by common ownership or control. Prior to December 1982, Parke Care Centers, Inc., purchased all of petitioner's stock and assets, including its rights under the lease agreement. Parke Care Centers is not related by common ownership or control to Suburban. Pet. App. 3a. On February 28, 1986, the Secretary's fiscal intermediary in Ohio, Community Mutual Insurance

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[2] The regulation is currently located at 42 C.F.R. 413.17.

[3] Because petitioner's complaint was dismissed for lack of jurisdiction, the facts alleged in the complaint are assumed to be true. See Pet. App. 3a.

Company (CMI), issued a Notice of Program Reimbursement to Salem Park based on its cost report for 1984. Applying the related-entity regulation set out above, CMI found that petitioner and Suburban were related parties in 1984, and that a portion of the rental payments made under the lease contract therefore must be disallowed. The total amount of the adjustments was greater than $1,000 but less than $10,000. Pet. App. 4a.

Petitioner exercised its right to request a hearing before CMI. The hearing officer did not find that petitioner and Suburban were related parties in 1984. But the hearing officer, applying Section 1011.2 of the Provider Reimbursement Manual quoted above, determined that rental payments made under the lease agreement were subject to the related-party principle because of the relationship between the parties to the lease agreement at the time the agreement was made. Petitioner sought review of the hearing officer's decision by a HCFA review officer. That officer affirmed the decision. Pet. App. 5a.

Petitioner then sought judicial review of the Secretary's final decision in the district court. Pet. App. 27a, 31a. It contended that application of the related party rule violated the Administrative Procedure Act, 5 U.S.C. 551-559, 701-706, the Medicare Act, and the Due Process Clause. Petitioner asserted that the court had jurisdiction under 28 U.S.C. 1331, 28 U.S.C. 1346, and 42 U.S.C. 1395*oo*(f)(1). Pet. App. 6a & n.4.

The district court granted the Secretary's motion to dismiss the action for lack of subject matter jurisdiction. The court held that it lacked jurisdiction under 42 U.S.C. 1395*oo* because petitioner did not meet the $10,000 amount-in-controversy requirement. The court also held that 42 U.S.C. 1395ii, which incorporates the preclusions of review in 42 U.S.C.

405(h), bars suit under 28 U.S.C. 1331 or 1346. Pet. App. 10a-14a.

3. The court of appeals affirmed. Pet. App. 2a-9a. The court of appeals agreed with the district court that petitioner did not satisfy the amount-in-controversy requirement for suit under 42 U.S.C. 1395*oo*, and that 42 U.S.C. 1395ii expressly barred petitioner's suit under 28 U.S.C. 1331 and 1346. The court rejected petitioner's argument that this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), requires that petitioner be able to obtain judicial review under 28 U.S.C. 1331. The court explained that *Michigan Academy* recognized a limited exception to the strict rule of 42 U.S.C. 1395ii only where Congress has provided no other avenue of judicial review. In this case, Congress expressly provided an avenue for judicial review under 42 U.S.C. 1395*oo*(f)(1), but precluded review of claims where the amount in controversy is less than $10,000. Consequently, the court held, petitioner could obtain judicial review only by meeting the requirements established by Congress, including the amount-in-controversy requirement. Pet. App. 6a-9a.

ARGUMENT

1. The lower federal courts have only such jurisdiction as Congress confers upon them by statute. *Christianson* v. *Colt Industries Operating Corp.*, 486 U.S. 800, 818 (1988); *Sheldon* v. *Sill*, 49 U.S. (8 How.) 441, 449 (1850). No statute confers jurisdiction on the district court in this case.

The district court plainly lacked jurisdiction under 42 U.S.C. 1395*oo*. That Section provides for judicial review of HHS provider reimbursement decisions only if the amount in controversy is at least $10,000,

or if a group of providers has aggregate claims of at least $50,000. Since petitioner's claim is for less than $10,000, jurisdiction cannot be based on Section 1395*oo*.

Nor is there jurisdiction under 28 U.S.C. 1331 or 1346. Jurisdiction under those Sections is expressly barred by 42 U.S.C. 1395ii, which incorporates by reference the provisions of 42 U.S.C. 405(h). Section 405(h), in turn, provides:

> The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

Section 1395ii reflects Congress's clear intention to preclude judicial review of claims arising under the Medicare Act, except as provided in Section 1395*oo*. This intention is manifested by both the second and the third sentences of 42 U.S.C. 405(h), as incorporated by 42 U.S.C. 1395ii.

In its complaint, petitioner specifically sought review of the "final administrative decision of the Secretary," rendered through HCFA, on its claim for reimbursement under its cost report for 1984. Pet. App. 27a, 31a. The second sentence of Section 405(h) provides, however, that no "decision of the Secretary shall be reviewed by any * * * tribunal * * * except as herein provided"—i.e., except as provided in the Social Security Act itself. As we have explained, the Medicare title of the Social Security Act "provide[s]"

for judicial review in a case such as this only where the amount in controversy is $10,000 or more. Because that requirement is not met here, the "decision of the Secretary" that petitioner challenges is not subject to review in the "tribunal" whose jurisdiction it invoked—the federal district court.

The third sentence of 42 U.S.C. 405(h) likewise bars this suit. Petitioner is claiming a right to be reimbursed for certain rental expenses under the Medicare Act. That is plainly a claim "arising under" the Act. See *Heckler* v. *Ringer*, 466 U.S. 602, 615 (1984); *Weinberger* v. *Salfi*, 422 U.S. 749, 760-761 (1975). Accordingly, the third sentence of Section 405(h) bars petitioner from bringing an action under 28 U.S.C. 1331 or 1346.

2. Petitioner argues that, under this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), the district court had jurisdiction under 28 U.S.C. 1331. Petitioner misreads *Michigan Academy*. That case concerned a challenge to a regulation governing the amount payable under Part B of the Medicare program. At the time the case was decided, Congress had provided no forum in which to challenge amount determinations on claims for benefits under Part B.[4] In allowing a challenge to the regulation to proceed under 28 U.S.C. 1331, the Court relied on the fact that, if there were no jurisdiction under Section 1331, there would be *no* forum, administrative or judicial, in which such a challenge could be brought. See 476 U.S. at 680 (rejecting the "assumption that Congress contemplated

[4] Congress has since amended the statute to provide for judicial review of administrative decisions on Part B claims, subject to an amount-in-controversy requirement of $1,000. See 42 U.S.C. 1395ff(b)(1)(C) and (b)(2).

review by [carriers] of 'trivial' monetary claims, * * * but intended no review at all of substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare program.").

This case is quite different. Congress has expressly created both an administrative and a judicial forum in which a provider of services may challenge a reimbursement decision under Part A, including a challenge to the regulations and instructions that the intermediary and the Secretary followed in reaching their decision. Congress has, however, limited access to these forums by imposing an amount-in-controversy requirement in 42 U.S.C. 1395*oo* and by foreclosing other avenues of review in 42 U.S.C. 405(h). When Congress expressly creates a forum for judicial review of agency action, a plaintiff must meet the requirements that Congress establishes for access to that forum. Accordingly, a district court is not free to disregard the amount-in-controversy requirement that Congress has established as a prerequisite for judicial review in a case such as this. See generally *Block* v. *Community Nutrition Institute*, 467 U.S. 340, 348 (1984) (upholding limitations on judicial review where absence of restrictions "would severely disrupt * * * complex and delicate administrative scheme").

This case is governed, not by *Michigan Academy*, but by *Heckler* v. *Ringer*, 466 U.S. 602 (1984). In that case, an individual who was eligible for Medicare benefits wished to have an operation known as a bilateral carotid body resection (BCBR) to relieve his suffering from respiratory distress. The Secretary, acting through HCFA, had issued an instruction that no payment was to be made for such surgery. Ringer and other plaintiffs brought suit challenging the Secretary's instruction on various constitutional and

statutory grounds, including denial of due process of law. The plaintiffs alleged jurisdiction under 28 U.S.C. 1331.

This Court held that the federal courts had no jurisdiction over the plaintiffs' claims because the plaintiffs had not exhausted their administrative remedies. The Court noted that, under Part A of the Medicare Act, plaintiff Ringer would be entitled to judicial review of his constitutional and statutory claims if he had the BCBR surgery, submitted a claim for payment to the Secretary, and ultimately had the claim administratively rejected after exhaustion of his administrative appeals. *Ringer*, 466 U.S. at 606-607. The Court held that 42 U.S.C. 1395ii (which makes 42 U.S.C. 405(h) applicable to the Medicare Act) barred the plaintiffs from seeking judicial review of their claims by any route other than the one expressly provided by Congress. 466 U.S. at 614-615, 622-623.

Ringer directly supports the court of appeals' decision in this case. It holds that where Congress has created an exclusive avenue for judicial review of constitutional and statutory challenges to Medicare rules and regulations, but has also established requirements that limit access to that forum, plaintiffs may obtain judicial review only if they meet those requirements. See also *Weinberger* v. *Salfi*, 422 U.S. 749, 762 (1975) ("[T]he plain words of the third sentence of § 405(h) do not preclude constitutional challenges. They simply require that they be brought under jurisdictional grants contained in the Act."). Here, petitioner does not meet the amount-in-controversy requirement by which Congress has limited access to the forum it has created for judicial review of provider reimbursement decisions. Accordingly,

the court of appeals correctly held that the district court had no jurisdiction over this case.

3. Petitioner contends that the court of appeals' decision conflicts with *Beverly Hospital* v. *Bowen*, 872 F.2d 483 (D.C. Cir. 1989). But in *Beverly Hospital* the court held, in the unique circumstances of that case, that there was no way any provider could have challenged the Secretary's actions in a proceeding under 42 U.S.C. 1395*oo*. 872 F.2d at 486. Accordingly, the court held that there was no expressly created forum for judicial review of the Secretary's actions. In the present case, in contrast, there is a judicial forum in which providers can challenge the Secretary's rule; petitioner simply does not meet the amount-in-controversy requirement for access to that forum. Thus, there is no conflict between this case and *Beverly Hospital*.

We note that the court of appeals' decision in this case is in some tension with *Bartlett* v. *Bowen*, 816 F.2d 695 (D.C. Cir.), reh'g order vacated, 824 F.2d 1240 (D.C. Cir. 1987), a decision that petitioner does not cite. In that case, the plaintiff's decedent filed a Part A Medicare claim in the amount of $286, which was denied. The plaintiff claimed that the denial had violated her decedent's First Amendment right freely to exercise her religion (because it was based in part on her use of a Christian Science facility). Even though the Medicare Act limits judicial review of individual Part A claims to those cases where the amount in controversy is at least $1,000, see 42 U.S.C. 1395ff (b)(2)(A), the D.C. Circuit held that, because of the constitutional nature of the plaintiff's claim, the district court had jurisdiction.

There is no occasion to grant certiorari here to resolve any tension between this case and *Bartlett*. First, petitioner does not even cite *Bartlett* in its

petition for a writ of certiorari. Indeed, petitioner expressly disclaimed reliance on that decision in the court of appeals. See Pet. C.A. Reply Br. 12-13 (*Bartlett* "has no applicability to Appellant's appeal"). Second, *Bartlett* did not involve 42 U.S.C. 1395*oo*, but instead concerned 42 U.S.C. 1395ff(b), a different provision of the Medicare Act that applies to individuals rather than providers of services. (The difference may be significant because providers of services agree to participate in Part A of the Medicare program, while individuals have no choice whether to pay Medicare taxes and are automatically enrolled.) Third, six judges of the D.C. Circuit indicated that they believed the decision in *Bartlett* to be highly doubtful or incorrect. See 824 F.2d at 1247 (Silberman, J., concurring in the denial of rehearing en banc) ("[W]ere I forced to choose, I would be inclined to favor the dissent's analysis."); *id.* at 1247-1248 (Bork, Starr, Buckley, Williams, & D.H. Ginsburg, JJ., dissenting from the denial of rehearing en banc) (panel's decision is "clearly wrong," or "at the very least, highly dubious."). And as Judge Silberman observed (*id.* at 1247), the panel's remarks on the constitutional issues were dicta that will not bind the D.C. Circuit in future cases. Hence, it is entirely possible that the D.C. Circuit will revisit and modify *Bartlett*.

Finally, the plaintiff in *Bartlett* "raised a serious challenge to the constitutionality of the Medicare Act on its face." 816 F.2d at 701. In contrast, petitioner's constitutional claim—which concerns only an administrative instruction and not the Act itself— appears to be frivolous. There is simply no serious argument that the Constitution prevents the Secretary from including in the Provider Reimbursement Manual a section stating that if a provider and a supplier are related by common ownership or control at the time a

contract is signed, the contract will be treated as if the provider and supplier remained subject to common ownership or control for the life of the contract. Nor is there any plausible constitutional argument that such a provision must be adopted through a rule-making proceeding under the APA, or that such a provision (which follows directly from the related-party principle set out in 42 C.F.R. 405.427 (1984)) may not be applied to contracts in existence when it was issued.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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APRIL 1992